Family Planning in a Healthy, Married Population: Operationalizing the Human Rights Approach in an Israeli Health Service Setting

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Abstract: A community health center in Israel, delivering services to a geographically defined population, attempted to formulate goals for its postpartum family planning service. Taking into account the pronatalist climate in Israel along with the good health status of the population served by this center, it was decided that the community-wide goal of the family planning program was to ensure the rights of couples to decide freely and responsibly on the number and spacing of their children. Specific process and outcome objectives were developed based on helping couples define and clarify their family planning goals, and assisting them to achieve these goals. Preliminary evaluation of the intervention based on the objectives showed that 84.0 per cent of the cohort of women who gave birth in 1980 (n = 212) had specific postpartum planning goals as opposed to 69.0 per cent of women who gave birth in 1977 (n = 242). The percentage of women experiencing unplanned pregnancies during the two years after birth was reduced by 46 per cent in the 1980 cohort (6.1 per cent of the women) as compared with the 1977 cohort (11.2 per cent). (*Am J Public Health* 1984; 74:830–833.)

Introduction

The World Health Organization has stated that the objectives of family planning in health services should be integrated with general societal objectives, and that it is the responsibility of health professionals to define family planning program goals.[1] Formulating family planning objectives for health services in developing countries is relatively clear: the aim is most often to lower the birth rate. Defining family planning goals for health services in countries where the general societal objective is pronatalist, or where there are no defined demographic goals, is problematic. Although fertility limitation may be the goal for a subgroup at high risk for maternal-child mortality or morbidity, the goals of a family planning service that deals with a healthy, married population are less clear. In this article, we will examine the process that led to the formulation of family planning goals in a community-oriented primary health care setting in Israel, and describe preliminary outcome and process evaluation for the goals that were developed.

Family Planning in Israel

Israel has no explicit population policy as expressed in a coordinated body of legislation. However, the Jewish-Arab demographic issue, as well as internal political, economic, and religious considerations contribute to a pronatalist climate. A Demographic Center, established in 1968 and attached to the Prime Minister's office, had the original mandate of raising the declining natality of the Jewish population, while there was no policy to effect changes in the high fertility of the Israeli Arabs.[2] Awareness of the problems caused by the socioeconomic gap between Jews from North African or Asian countries and those of Western origin caused some questioning of the unequivocal pronatal stance. It was felt that the persistence of the fertility differential between these two groups might contribute to perpetuating the devisive social gap.[2]

Until the mid 1970s, public family planning services were almost non-existent, and many couples either used no contraception or utilized relatively ineffective methods such as withdrawal.[3,4]* Abortion, although illegal except for health reasons, was widely prevalent.[4]

In recent years there has been an increase in the use of modern contraceptives.[5]** Abortion was virtually legalized in 1977, but in 1980 was restricted for married women because of pressure from the religious parties in the government coalition.

The Israeli Family Planning Association has recently reiterated its philosophy that "the planning of pregnancy timing and spacing and the prevention of unwanted pregnancies are essential values which allow each couple to build its family according to its values, beliefs, needs and abilities. The aim is to encourage natality by free and informed choice for the sake of maternal, child, and family health."[6]

With this general background, we will describe the family planning service at the Hadassah Community Health Center attached to the Department of Social Medicine of the Hebrew University-Hadassah School of Public Health and Community Medicine. This health center serves as a teaching base for public health professionals, where the principles of community health are practiced in a primary care setting.

Description of the Service

All families living in a designated geographic area are eligible for free preventive maternal and child health services at the Center. Ninety-five per cent of the families in the area utilize the Center for well-baby care. The population is Jewish and married. In recent years most young mothers have been Israeli born, middle class, and with high school education.

Family planning is an integral part of the maternal and child health services. A structured intervention includes postpartum contraceptive counseling and provision of con-

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*Kurtzman C: Contraceptive practices of mothers and young infants in a West Jerusalem neighborhood. Unpublished MPH thesis, Hebrew University, 1974.

**Sharma SK: A comparative study of contraceptive practices and client satisfaction in a community based and hospital based family planning service. Unpublished MPH thesis, Hebrew University, 1980.

traceptives at cost with follow-up care for two years, a period in which mothers routinely visit the service for well-baby care. Counseling is done by public health nurses who also provide general mother and child health care to these families. Family physicians provide contraceptive services.

From 1971 to 1979, postpartum use of oral contraceptives, IUDs, and the diaphragm increased from 22.3 per cent to 54.4 per cent, while the use of withdrawal decreased from 60.2 per cent to 25.5 per cent. These data pertain to women three to four months postpartum. While these findings gave the staff some feeling of achievement, in 1979 we began to question whether an increase in the use of effective contraceptives was a relevant measure of the success of the service.

The Department of Social Medicine to which this health center is attached has a philosophy of community-oriented primary health care[7] whereby community health problems are dealt with through structured programs with the following characteristics: a defined target population; measurable objectives; structured intervention; monitoring and periodic evaluation. It became clear that the family planning service had some of the characteristics of such a program but lacked clearly stated measurable objectives.

Formulating Objectives

We reviewed the available community information on family planning related health factors. Our population had a low infant mortality rate, averaging 10 per thousand from 1977–1979, and there had been virtually no maternal mortality in the community in recent years. Only 4.2 per cent of women giving birth in 1977 were below age 20, while 9.7 per cent were aged 35 or over.*** Between 1971–1978, only 5 per cent of 1,922 live births were of a birth order of 5 or more.†

Examining live birth intervals in this community, it was found that between 1971–1978 only 4.1 per cent of births were of intervals of 12 months or less and 30.6 per cent were of intervals of 24 months or less.† Data on pregnancy intervals in this community were not available, but the information at hand made a spacing related objective questionable.

Although the estimated rate of abortions is high in Israel, our service records showed that only 8 per cent of women giving birth in 1977 reported having had a previous abortion. While it may be assumed that abortions are underreported, in view of the controversial evidence concerning the health effects of abortion among parous women in Israel,[8,9] we did not feel that there was a case for an abortion-related health objective in this community.

Based on the above evidence, we concluded that although there would be individual health considerations for family planning, we did not feel justified in formulating community-wide health objectives. After much discussion, we arrived at a consensus that the relevant basis for our program was the human rights objective. We were now faced with attempting to operationalize what is in essence a philosophical statement: Couples have the basic human right to decide freely and responsibly on the number and spacing of their children.[10]

Operationalizing the Human Rights Objective

"Deciding freely" implies that care providers do not decide for the clients or influence their choices. "Deciding responsibly" implies that the care givers provide information when necessary and the opportunity for clients to clarify their values in respect to patterns of family formation in general, and specifically in respect to the timing of their next pregnancy.

Therefore, it seemed to us that the human rights objective could be operationalized in health services by: 1) helping people to clarify what they want; and 2) providing them with the information and/or technology to achieve their desired goals.

Until 1980, the service provided contraceptive counseling and care, but did not address itself to helping people clarify their family planning goals.

In the immediate postpartum period, women were always asked the question, "When do you want to become pregnant again?" Of 200 women responding to this question in 1977, 53.0 per cent had a planning goal of either no additional pregnancies, or an additional pregnancy at a specified time; 31.0 per cent responded that they did not know when they wanted to become pregnant again; and 16.0 per cent said that they did not wish to plan their next pregnancy because of religious or other reasons.

This led us to consider extending the counseling focus beyond the subject of contraception, to include value clarification related to family planning decision making. At first, nurses had difficulty in seeing themselves in this new role. A simple counseling model†† was developed through discussion during in-service education sessions, and eventually this aspect of counseling was accepted by nurses and became part of the service.

In the initial postpartum period, the issue of family planning is raised by the nurse. A woman (or couple) who gives a definite response to a question involving the intended timing of the next pregnancy (i.e., desire for additional pregnancy after a specified period of time, for no more pregnancies, or for becoming pregnant when God or nature wills it) is helped to clarify the intention and to think about considerations involved in the planning. Sometimes, health-related information is provided so that this may be incorporated in the client's consideration. When a woman (or couple) does not know when the next pregnancy is desired, the nurse presents family planning in the context of planning of various aspects of everyday life. Benefits of planning may be discussed as well as theoretical considerations people might have for family planning. After thinking about the possible relevance of various considerations to her own situation, the woman (along with her partner) hopefully develops short- or long-range goals. Birth control information is offered to all women, and counseling is provided based on the goals of each couple as well as on the usual contraceptive considerations. Throughout the counseling process, discussion of perceived attitudes and consideration of the partner, and encouragement of communication with the partner are included.

Service evaluation in December 1979 showed that 11.2 per cent of the women who gave birth in 1977 had an unplanned pregnancy within the two year postpartum fol-

***The service included routine amniocentesis referral for all pregnant women aged 37 or older.

†Hematorn C: The study of child spacing in a West Jerusalem neighborhood. Unpublished MPH thesis, Hebrew University, 1980.

††Presented at the Israeli Family Planning Association National Conference, January 1980, Tel Aviv; and at the Conference on Primary Health Care in Industrialized Countries, November 1983, Bordeaux, France.

low-up period. Unplanned pregnancy was defined by two criteria: 1) that the postpartum planning statement of the woman was to delay or prevent pregnancy; and 2) that the subsequent clinical record showed that the woman stated that the pregnancy was unplanned in answer to a routine question asked at the first antenatal visit.

Half of the unplanned pregnancies occurred among women using no contraceptive method. Record reviews showed that the non-contraceptors who experienced an unplanned pregnancy became pregnant either early in the postpartum period before adopting a contraceptive, after spontaneous IUD expulsion, or after IUD removal because of undesirable side effects. Since we felt that at least 50 per cent of unplanned pregnancies were preventable, a goal was set to reduce by half the incidence of unplanned pregnancies.

Preliminary Evaluation

The objectives (see Appendix) were ratified by the staff in December 1979, and the process of redesigning and introducing new records took another year. Therefore the first systematic evaluation based on these objectives and utilizing the specifically designed recording system will not be possible until 1984 when the cohort of women who gave birth in 1981 have completed their two year follow-up period.

In the interim, we have undertaken a preliminary evaluation of the cohort of women giving birth in 1980, based on the objectives and utilizing the somewhat limited data available from the old recording system. We compared these data to those available from the 1977 cohort. Data analysis for the 1978 and 1979 cohort had been suspended until objectives were formulated and adopted by the service.

Comparison of demographic data from the two cohorts is shown in Table 1.

We found that 84.0 per cent of the population stated a specific planning goal in 1980, compared to 69.0 per cent in 1977 (Table 2). The percentage of women who stated that they did not know when the next pregnancy was wanted was cut in half.

Our old recording system allowed us to identify only those women who stated they wanted no more children or who planned to delay their next pregnancy for at least three years: 79.0 per cent of them were using relatively effective contraceptive methods (IUD, pill, or barrier methods) by three months postpartum; 16.2 per cent were using coitus interuptus or rhythm; and 4.8 per cent were using no method.

In 1980, 6.1 per cent (as compared to 11.2 per cent in the 1977 population) had an unplanned pregnancy during the two-year follow-up period. Four of the 13 unplanned pregnancies in 1980 were due to IUD failures, the remainder became pregnant during non-use of contraceptives, usually after stopping use of the IUD or pill. Our outcome objective (2b in the Appendix) was basically achieved, although we felt that unplanned pregnancies could be further reduced in this population.

Looking at the process objectives (see Appendix), preliminary evaluation showed that 91.3 per cent of the 206 women in the program during the immediate postpartum period had a planning statement recorded in their files. While we were not able to determine whether counseling was provided within the specified six weeks after delivery, observation of service delivery and information from staff led us to assume that counseling is generally provided within this time period.

TABLE 1—Demographic Data of Women who Gave Birth, Hadassah Community Health Center, 1977, 1980

Demographic Indices	Year of Giving Birth 1977 (n = 242)	1980 (n = 212)
Age		
Age Range	17–42	18–47
Median age	26	27
% <20 years	4.2	2.9
% ≥35 years	9.7	6.0
% women born in Israel	67.9	66.9
Origin*		
% Near Eastern or N. African origin	51.0	50.0
% European or American origin	26.2	34.6
% Israeli origin	22.8	15.4
Parity		
% parity 1	45.2	34.8
% parity 2	30.3	32.8
% parity 3	15.8	20.7
% parity 4–6	8.7	11.6
Education		
Median years of education	12	12
% 0–8 years	13.5	10.1
% 9–12 years	56.1	53.7
% 13–22 years	30.4	36.2
Social class**		
% S.C. I or II	Unknown	38.6
% S.C. III	Unknown	53.0
% S.C. IV or V	Unknown	8.4

*Origin is defined as country of birth of woman, or if she is Israeli born, of her father. This has been grouped into geo-cultural areas.

**Social class is based on the British Registrar General's definitions of social class,[12] as revised by the Dept. of Social Medicine, Hebrew University, Hadassah, School of Public Health and Community Medicine.

Since contraceptive information and counseling is usually offered directly after the discussion on family planning, we may assume that objective 2c was met to the same extent as objective 1b.†††

Except for one woman who refused to participate in the program, contraceptive follow-up was provided at specified intervals during the two-year period: 91.1 per cent of the women residing in the area during the entire follow-up period had at least four family planning follow-up recordings in their files, with the remainder having at least two follow-up recordings.

We were not able to determine the extent of referral to fertility services (objective 2e) from the old record system.

Finally, it must be noted that in formulating objectives, we made an a priori assumption that family planning per se is a desirable goal. While it may be widely accepted that people have the basic right to plan their fertility, and that this right should not be interfered with, having health services promote planning is not necessarily a correlate of this philosophy. Nevertheless, it seems to us that responsible fertility decision-making is a legitimate goal to be pursued by a health service-based family planning program.

†††The new recording system will allow us to evaluate this objective separately, including the determination of the proportion of women who desired contraceptive information and counseling.

Table 2:—Percentage of Women Giving Birth in 1977 and 1980 by Stated Postpartum Planning Goals, Hadassah Community Health Center

Postpartum Planning Goals	Year of Giving Birth 1977	1980
No more children	16.0	23.9
Pregnancy in 0–2 years	16.5	16.5
Pregnancy in 3+ years	20.5 } 69.0	40.4 } 84.0
No planning because of religious or ideological reasons	16.0	3.2
Don't know when next pregnancy wanted	31.0	16.0
TOTALS	100.0	100.0
	n=200*	n=188**

*An additional 42 women did not have a postpartum planning goal recorded in their files; of these, 10 were not living in the area during the immediate postpartum period.

**An additional 24 women did not have a postpartum planning goal recorded in their files; of these, six were not living in the area during the immediate postpartum period.

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APPENDIX

Objectives of Family Planning Program

General Objectives

1. To help the population* define and clarify their family planning goals.
2. To assist them to achieve their family planning goals.

*The population is comprised of all postpartum women, from the time of delivery until two years thereafter (or until pregnancy occurs within that period), who reside in the defined geographic area served by the health center.

Specific Objectives

Outcome Objectives

1a. To increase the percentage of the population who state a specific family planning goal** from 69.3 per cent to 90 per cent.

2a. To assist 100 per cent of the population expressing family planning goals of preventing or delaying pregnancy to adopt a contraceptive method during the first three postpartum months.

2b. To decrease the percentage of the population experiencing an unplanned pregnancy*** during the two years after delivery from 11.6 per cent to 6 per cent.

Process Objectives

1b. Counseling will be provided to 100 per cent of the population to help them and their partners consider and clarify their family planning goals. The initial counseling will be provided within six weeks after delivery.

1c. Monitoring and updating of family planning goals will be done at specified follow-up intervals during the two-year period after delivery.

2c. Contraceptive information and counseling will be offered to 100 per cent of the population within the first six weeks after delivery.

2d. Contraceptive follow-up and continuing service will be provided at specified follow-up intervals during the two-years period after delivery.

2e. Fertility service referral will be offered to all women who expressed an intention to become pregnant and fail to do so after six months.

**Specific family planning goals include preventing pregnancy (wanting no more children), delaying pregnancy for a specified period of time, getting pregnant as soon as possible, and planning not to plan (because of religious or ideological reasons).

***Unplanned pregnancy is defined as pregnancy occurring when preventing or delaying pregnancy was stated as a planning goal.